

not believe that this is due to missing forms. Possible reasons include lack of cover for meal and other breaks and some patients bypassing the triage station during busy periods.

Health authorities must purchase health care for their resident populations based on need and cost effectiveness of care. Formal nurse triage schemes add to the costs of accident and emergency departments but may not yield commensurate benefits. Without question, some form of prioritisation will benefit patients in most urgent need of care, but does it need to be formalised and called "nurse triage?"

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## A survey of hospital toilet facilities

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### Abstract

**Objective**—To assess the quality of toilet facilities available for disabled people in a large provincial teaching hospital.

**Design**—Survey of toilet facilities for patients on the wards and in the outpatient department.

**Setting**—Teaching hospital in Leeds.

**Results**—Although the quality of toilet facilities varied, none met the standards recommended by the British Standards Institution. The worst facilities were found on a ward accommodating elderly patients, where the toilets were unsuitable for use by disabled people and bedside commodes had to be used instead.

**Conclusion**—Toilet provision within a major hospital failed to meet standards required for disabled people. Admission to hospital may therefore result in loss of independence and dignity. If hospitals are to be centres of excellence, greater consideration must be given to the requirements of disabled people in the design of new wards, and current inadequate facilities should be upgraded.

### Introduction

One in seven adults in the United Kingdom has at least one disability.<sup>1</sup> The prevalence of disability is probably even higher in hospital patients. One problem often cited by disabled people is that of access to toilets.<sup>2</sup> Without optimum facilities in hospital, disabled people may be made uncomfortable, embarrassed, and unnecessarily dependent on nurses. We report a study of toilet facilities of a provincial teaching hospital.

### Method

We surveyed the patients' toilets in 13 wards and the outpatient department. The wards assessed were

geriatric, psychogeriatric, medical, rheumatological, neurological, orthopaedic, and general surgical. Every medical, surgical, and orthopaedic ward was similarly designed, so only one of each specialty was inspected. The psychogeriatric, rheumatological, and neurological wards were the only wards of their respective specialties. The geriatric wards were of various ages and designs, so each was surveyed.

Comparisons were made with British Standards for access for disabled people to buildings.<sup>3</sup> On most wards only the toilet the nurses recommended for disabled patients was inspected; the ward toilets not surveyed were likely to be worse in terms of accessibility and equipment. On one ward four toilets were surveyed to assess variability in standards.

### Results

Seventeen toilets were surveyed. The findings and the features of the ideal ward toilet<sup>3,4</sup> are presented in the table.

The four toilets surveyed on the same ward were similar in number and type of substandard features.

### Discussion

A hospital environment excelling in the provision of appropriate equipment would promote comfort and independence and demonstrate to patients the range of aids and appliances available to enable them to maintain independence in the community.<sup>5</sup>

None of the toilets surveyed met British Standards, although the rheumatology ward came closest. The worst toilet was on a geriatric ward. It was neither signposted nor labelled. It measured only 1.5 m by 0.9 m and the door was only 70 cm wide. The washbasin could not be reached from the toilet seat, which was one of the lower ones (43 cm). There were no toilet or

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Comparison of features of ideal toilet with actual toilets in wards of a teaching hospital

Feature	Ideal	Actual	Comments
Toilet:bed ratio	1:3 to 1:4	1:2.6 to 1:6.8	Standard met only on psychogeriatric ward. Worst ratio on 3 geriatric wards
Signposting	Clear signposting by words and symbols	Only 1 toilet signposted	
Labelling	Large clear labelling on door	10 Had small labels; 7 had none	
Locking	Lever handled door that locks from inside but can be opened from outside in emergency	All could be unlocked from outside in emergency; 13 could be locked from inside	One had curtain instead of door
Door opening	Door opens outwards to ease passage of wheelchair	10 Outward 1 Inward 5 Sliding	
Door width	≥100 cm	70-91 cm	11 Were ≤80 cm wide
Cubicle length	≥2 m	1.6-2.6 m	7 Toilets met standard
Cubicle width	≥1.5 m	0.9-1.82 m	5 Cubicles met standard Irregular shape and inward opening door compromised dimensions of 2 cubicles The 3 toilets meeting standards for both length and width were on geriatric, psychogeriatric, and surgical wards
Toilet seats	≥45 cm from floor level Toilet seat raise should be available	42-47 cm	12 Were <45 cm high
Flush mechanism	Adapted for ease of use	Adapted by means of pushbuttons or long handles in 8 toilets	All were suitable for addition of raised seats
Toilet paper	Plentiful Easily reached from seat Single sheets detachable by person using only one arm	All lavatories equipped with paper In three cases paper could not be reached from seat No paper could be obtained with only one hand	
Washbasin	≤75 cm high Reachable from toilet seat, so wheelchair users can wash hands while seated	75-85 cm Only two basins could be reached from toilet seat	Only one basin was 75 cm high
Taps	Adapted, long handled	Only three had adapted taps	
Rails	Fixed horizontal rail on wall side of cubicle, reachable from toilet seat Horizontal drop down rail on other side of toilet, to enable wheelchair occupant to slide across from chair to toilet seat, rail accessible from toilet seat	14 Toilets had recommended rail; others had no rail or a fixed diagonal or vertical rail Only 3 toilets had recommended rail; one of these could not be reached from seat. 5 Had fixed horizontal rail, 1 had fixed diagonal rail, 1 had fixed vertical rail, 7 had no rails	Only rheumatology and neurology wards fulfilled British Standards for toilet rails
Flooring	Fixed vertical rail above and to side of washbasin Pull rail to rear of door to facilitate closure	Standard met only on rheumatology ward No cubicle had such a rail	
Mirror	Non-slip and non-absorbent Lower edge no higher than 90 cm from floor to be used by wheelchair occupant	Non-slip surface only on rheumatology ward 10 Lavatories had mirrors; only on rheumatology ward was mirror at height recommended	
Safety alarm	String pull, clearly labelled	11 Cubicles had alarms, functioning in only eight	

washbasin rails. The taps were not adapted. There was no alarm and no mirror. This was one of three toilets on a 20 bed ward. Disabled patients were unable to use this toilet, so the nurses were obliged to recommend the use of commodes for these patients.

It is unlikely that this hospital is alone in its inadequate toilet facilities. A study in Edinburgh showed that limitations in the provision of facilities on the ward led to increased dependence by the patients on the nurses.<sup>6</sup> The haphazard provision of ward toilet rails has been observed elsewhere.<sup>7</sup> A survey of 140 elderly people at home showed 5% using raised toilet seats, a further 8% needing them, 9% using a fixed toilet rail, and a further 11% needing one.<sup>8</sup> One survey found that 33% of people over 75 at home used toilet aids and 43% of women over 85 could not get to the toilet without aids or personal assistance.<sup>9</sup> Such people are disadvantaged when admitted to hospitals where

toilets do not meet the British Standards for access by disabled people.

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Perforation of gloves in an accident and emergency department

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There is increased concern regarding the risk of transmission of diseases such as those caused by hepatitis virus and HIV, particularly from high risk groups who attend accident and emergency departments, such as drug addicts. Surgeons sustain needle perforation of their gloves during difficult and prolonged operations,<sup>1</sup> but simple suturing of wounds under local anaesthesia would be expected to present a minimal risk to an accident and emergency doctor. This study defines the extent of the risk and identifies

risk factors to doctors working in accident and emergency departments.

Subjects, methods, and results

We tested for perforations 338 pairs of single use, prepacked, sterilised gloves (Ansell) used consecutively for minor suturing procedures performed under local anaesthesia. The cuff was secured by rubber rings to the end of a specially constructed apparatus that delivered 500 ml (+/- 5%) of water into the glove. Each glove was tested within 24 hours of its use: each finger, the palm, and the dorsum of the glove were examined for leakage when pressure was applied.<sup>2</sup> Thirty pairs of unused surgical gloves were used as controls. Thirteen senior house officers, two senior registrars, and one consultant (all of whom were right handed) participated in this study. We noted whether perforation of a glove had been suspected and whether the patient was confused or uncooperative because of